



June 25, 2007


Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1541-P**
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Norwalk:

The American Health Information Management Association (AHIMA) is pleased to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed refinement to the Medicare Home Health Prospective Payment System (HH PPS) and calendar year (CY) 2008 Rates, as published in the May 4, 2007 *Federal Register* (CMS-1541-P).

AHIMA is a professional association representing more than 51,000 health information management (HIM) professionals who work throughout the healthcare industry and whose work is closely engaged with the diagnosis and procedure classification systems that serve to create the diagnosis related groups (DRG) discussed in this proposed rule. As part of our effort to promote consistent coding practices, AHIMA is one of the Cooperating Parties, along with CMS, the Department of Health and Human Services' (HHS) National Center for Health Statistics (NCHS), and the American Hospital Association (AHA). The Cooperating Parties oversee correct coding rules associated with the *International Classification of Diseases Ninth Revision, Clinical Modification* (ICD-9-CM). AHIMA members are also deeply involved with the development and analysis of healthcare secondary reporting data including that associated with quality measurement and in the development, planning, implementation and management of electronic health records.

We urge CMS and HHS to take immediate action to secure the adoption and implementation of ICD-10-CM as a replacement of the ICD-9-CM diagnosis coding system, and supporting transaction standards, as early as possible. The refinements to the HH PPS described in this proposed rule, as well as any future refinements, would greatly benefit from the greater level of specificity and clinical detail in ICD-10-CM.

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II-A: Refinements to the Home Health Prospective Payment System (72FR25358)

II-A-2b – Addition of Variables (72FR25357)

AHIMA agrees with the CMS proposal that an episode should not be eligible to earn more than one score for the same diagnosis group. This is comparable to the CC Exclusion List used in the hospital inpatient PPS, whereby complications/comorbidities that are closely related to the principal diagnosis do not cause a case to be assigned to a higher-weighted DRG.

We also support the proposals to assign scores to certain secondary diagnoses used to account for the cost-increasing effects of comorbidities and to combinations of certain conditions in the same episode.

II-A-2c – Addition of Therapy Thresholds (72FR25362)

We appreciate CMS' support for adherence to the coding guidelines concerning proper sequencing of etiologies and manifestations, as stipulated in the *ICD-9-CM Official Guidelines for Coding and Reporting*.

The proposed rule notes that V codes are less specific to the clinical condition of the patient than numeric diagnosis codes. It further indicates that medical review activities continue to report an excessive utilization of the V57 codes, signaling a possible non-compliance with correct coding practice related to the V codes. According to the *ICD-9-CM Official Guidelines for Coding and Reporting*, there are a number of instances when V codes must be used instead of the code for the acute clinical condition. For example, V codes for aftercare must be used instead of the code for the acute condition when the initial treatment of a disease or injury has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of a disease. Additionally, when the primary reason for the admission to home health is rehabilitation, the appropriate V code from category V57 should be assigned. Aftercare and rehabilitation are common reasons for admissions to home health care, and therefore, it is not unreasonable that these V codes would be frequently used for reporting of home health services. However, prior to allowance of V codes on OASIS, we believe there was significant non-compliance with the official coding guidelines pertaining to the use of V codes.

Since the *ICD-9-CM Official Guidelines for Coding and Reporting* were named as part of the ICD-9-CM coding standard under the HIPAA regulations for electronic transactions and code sets, V codes must be used in accordance with these guidelines and codes for acute conditions may not be assigned when prohibited by the guidelines.

II-A-2d – Determining the Case Mix Weights (72FR25386)

AHIMA opposes CMS' proposal to reduce the HH PPS standardized payment rate by 2.75 percent each year up to and including CY 2010 to eliminate the suggested effect of changes in coding or classification that do not reflect real changes in case mix. This proposed annual reduction percent is based on CMS' estimate of the nominal change in case mix that occurred between the HH interim payment system (IPS) baseline and 2003. It has no basis in actual current data or research pertaining to home health coding practices and their impact on case mix.

AHIMA has long been an advocate of consistent coding practices and serves as one of the four Cooperating Parties responsible for development of the *ICD-9-CM Official Guidelines for Coding and Reporting* and the content of the American Hospital Association's *Coding Clinic for ICD-9-CM*. These publications provide official industry guidance on complete, accurate ICD-9-CM coding, without regard to the impact of code assignment on reimbursement. AHIMA's Standards of Ethical Coding stipulate that "coding professionals are expected to support the importance of accurate, complete, and consistent coding practices for the production of quality healthcare data." Therefore, AHIMA believes that all diagnoses should be coded and reported in accordance with the official coding rules and guidelines and does not advocate the practice of coding diagnoses only when they affect reimbursement.

AHIMA does not believe any payment adjustment to account for case mix increases, which are attributable to coding improvements, should be made until CMS has conducted appropriate research involving current data to determine the extent of the actual impact of coding practices on case mix at the present time. We acknowledge that at the time the HH PPS was first introduced, coding accuracy by home health agencies was not at the level it should have been. However, much has changed since then. Increased attention to the quality of coding and documentation as a result of the role coding plays in reimbursement has led to much-improved coding practices. Also, coding quality among home health agencies likely varies, so making an across-the-board payment reduction raises an equity issue that CMS needs to consider.

II-F: Home Health Care Quality Improvement (72FR25449)

AHIMA supports CMS' proposal to add two additional quality measures for emergent care for wound infections, deteriorating wound status, and improvement in status of surgical wound.

Conclusion

AHIMA appreciates the opportunity to comment on the proposed refinements to the Medicare HH PPS program for CY 2008.

We recommend that CMS promote adherence to the ICD-9-CM coding rules and the *ICD-9-CM Official Guidelines for Coding and Reporting*, including the rules and guidelines pertaining to the appropriate use of V codes, by home health agencies. In order to ensure that CMS' own reporting instructions are consistent with ICD-9-CM rules and guidelines and promote accurate and consistent coding, we recommend that CMS collaborate with AHIMA on any updating or other revision of their instructions pertaining to the reporting of ICD-9-CM diagnosis codes.

AHIMA does not believe any payment adjustment to account for case mix increases, which are attributable to coding improvements, should be made until CMS has conducted appropriate research involving current data to determine the extent of the actual impact of coding practices on case mix at the present time.

AHIMA urges CMS to actively promote HHS' adoption and implementation of the ICD-10-CM coding system in order to ensure the availability of appropriate, consistent, and accurate clinical information reflective of patients' medical conditions. The greater level of clinical detail and specificity in

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ICD-10-CM will provide much better data to support the refinements to the HH PPS outlined in the proposed rule for CY 2008, as well as any future refinements. Implementation of ICD-10-CM would improve CMS' and the healthcare industry's ability to measure quality, track outcomes, and capture differences in severity of illness. For example, the increased specificity in ICD-10-CM regarding postoperative complications and decubitus ulcers would provide better data for measuring quality of care and assessing patient severity (including improvement or deterioration of a decubitus ulcer). Use of ICD-10-CM would also provide a standardized reporting mechanism for significantly more clinical information than is possible with ICD-9-CM.

AHIMA stands ready to work with CMS and the healthcare industry to see that all these goals, including those of CMS for accurate payment, are met. If AHIMA can provide any further information, or if there are any questions or concerns in regard to this letter and its recommendations, please contact Sue Bowman, RHIA, CCS, AHIMA's director of coding policy and compliance at (312) 233-1115 or sue.bowman@ahima.org, or myself at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,

A handwritten signature in blue ink that reads "Dan Rode". The signature is written in a cursive, flowing style.

Dan Rode, MBA, FHFMA
Vice President, Policy and Government Relations

cc: Sue Bowman, RHIA, CCS